STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004975	A. BUILDING: _____ B. WING _____	C 11/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT CATHERINE REGIONAL HOSPITAL	2200 MARKET ST CHARLESTOWN, IN 47111

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S 000	INITIAL COMMENTS This visit was for the investigation of two (2) State complaints. Complaint # IN00077654 Unsubstantiated: Lack of sufficient evidence; Deficiencies unrelated to the allegations are cited. Complaint # IN00078873 Substantiated: Deficiencies related to the allegations are cited. Facility #: 004975 Date: 11-8-10 Surveyor: Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor QA: claughlin 01/06/11	S 000		
S 418	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(b)(1)(2) (b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows: (1) The action shall be documented. (2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care.	S 418		

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S 418	Continued From page 1 This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure appropriate action to address opportunities for improvement for 2 of 4 patient (#PF1, #PF4) records reviewed. Findings include: 1. Review of Policy titled Event Reporting on 11-8-10, most recently reviewed by the facility 10/10, indicated the following: Definition: An event is an event which is out of the ordinary and has a potential for or actual injury to a patient, visitor, or employee; occupational illness; or damage to hospital or patient property. This also includes unanticipated outcomes/adverse events and medication errors. Under Policy indicates the following: In no case should the event report be filed with the medical record. Investigation into an event must begin within 24 hours of the event. Procedure, point 8 indicates: Event reports will be reviewed monthly at the Quality Council meeting with reporting to MEC and Governing Board for review and recommendations. 2. Review of patient medical records and occurrence reports on 11-8-10 indicated concern/complaints were voiced regarding bruises on 2 patients (#PF1 and #PF4). Review of the facility complaint log lacked evidence these were treated as complaints/grievances, investigated or followed-up with written communication as complaints/grievances as required per facility policy. 2. Review of the facility Quality Assurance and Performance Improvement (QAPI) meeting minutes from July - October 2010 lacked evidence that these complaints/grievances were discussed or reviewed at the facility QAPI	S 418		

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S 418	Continued From page 2 meetings July - October 2010. 3. Interview with #S1 on 11-8-10 at 1411 hours confirmed the concerns/complaints of bruising found on patients #PF1 and #PF4 were not investigated, staff was not interviewed and the concerns were not discussed at the facility QAPI committee meetings or any other committee meetings from July - October 2010. 4. Interview with #S3 on 11-8-10 at 1415 hours confirmed the complaints of bruising found on patients #PF1 and #PF4 was not investigated, staff was not interviewed and the issues were not discussed at the facility QAPI meetings or any other committee meetings from July - October 2010.	S 418		
S 744	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure a complete medical record, including physician discharge orders, for 2 of 3 (#PM1, #PM3) patient medical records reviewed. Findings include: 1. Review of patient medical records on 11-8-10 indicated #PM1 was discharged to a nursing home on 8-2-10. Review of patient medical	S 744		

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S 744	Continued From page 3 records on 11-8-10 indicated patient #PM3 was discharged to a nursing home on 7-5-10. The patients' medical records lacked documentation of a physician discharge order for patients #PM1 and #PM3. 2. Interview with #S1 on 11-8-10 at 1400 hours confirmed there was no physician order to discharge patient #PM1. 3. Interview with #S1 and #S2 on 11-8-10 at 1540 hours confirmed there was no physician order to discharge patient #PM3.	S 744		
S 930	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. This RULE is not met as evidenced by: Based on document review and interview, the registered nurse failed to supervise and evaluate the care of patients by not ensuring facility nursing policies were followed for 1 of 3 (#PF1) patients in medical records reviewed. Findings include: 1. Review of facility nursing policy Personal Hygiene on 11-8-10 indicated the following: Each patient will receive a bath and /or shower no less than twice weekly. 2. Review of patient medical records on 11-8-10 indicated patient #PF1 was admitted to the behavioral health unit on 8-5-10 and received	S 930		

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S 930	Continued From page 4 showers on 8-6-10, 8-14-10 and 8-17-10. #PF1 did not receive a bath/shower from 8-6-10 to 8-14-10, which is 8 days. 3. Interview with #S1 on 11-8-10 at 1615 hours indicated patient #PF1 should have been on the Tuesday/Saturday bath/shower schedule and facility policy requires patients to have a bath/shower no less than twice weekly. #S1 indicated patient #PF1 should have had a bath/shower on 8-10-10 and confirmed patient #PF1 did not have a bath/shower for 8 days.	S 930		
S1164	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure bed alarms are tested and in good working order to assure patient safety. Findings include: 1. Review of facility occurrence reports on 11-8-10 indicated patient #PF3 was found on the floor at the bedside on 9-8-10. The occurrence	S1164		

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S1164	Continued From page 5 report indicated that a bed alarm was in place. 2. Interview with #S3 on 11-8-10 at 1428 hours indicated that bed alarms are checked daily to make sure they are in place. #S3 indicated that the bed alarms are not tested to assure they will alarm when a patient leaves the bed; they are only checked to make sure they are in place. #S3 indicated he/she does not know if the bed alarm worked at the time of patient #PF3's fall and indicated they are not tested and preventative maintenance is not conducted for the bed alarms.	S1164		